CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE (CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155222		IDENTIFICATION NUMBER:	A RIII	LDING	01	COMPI	LETED
		B. WIN			09/22/2	2011	
<u> </u>			P		T ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			VEST LINCOLN ROAD		
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			1	DMO, IN46902			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
K0000							
					This Disc of Commention is the		
	1	ode Recertification and	K(0000	This Plan of Correction is the centers Allegation of		
	State Licensure S	Survey was conducted by			compliance.Preparation and	d/or	
	the Indiana State	Department of Health in			execution of this plan of	3/01	
	accordance with	42 CFR 483.70(a).			correction does not constitu	ıte	
					admission or agreement by	the	
	Survey Date: 09	9/22/11			provider of the truth of the f	der of the truth of the facts	
	,				alleged or conclusions set f		
	Facility Number	. 000127			the statement of deficiencies.		
	Facility Number: 000127 Provider Number: 155222				The plan of correction is prepared and/or executed soley because it		
				is required by the provision of			
	AIM Number: 1	.00291430			federal and state law.	.	
	1 '	p Komsiski, Life Safety					
	Code Specialist						
	At this Life Safe	ty Code survey, Kindred					
	Transitional Care	e and					
	Rehabilitation-K	lokomo was found not in					
		Requirements for					
	1 ^	Medicare/Medicaid, 42					
	1 ^	3.70(a), Life Safety from					
	1 ^	•					
	1	00 edition of the National					
		Association (NFPA) 101,					
	1	e (LSC), Chapter 19,					
		Care Occupancies and					
	410 IAC 16.2.						
	This one story fa	acility was determined to					
	be of Type II (000) construction and was						
		The facility has a fire					
	1 - 1	th smoke detection in the					
	•						
	corridors, spaces open to the corridors and		- 1		1		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

resident rooms on north unit (100 hall).

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

94CY21

Facility ID:

000127

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER: 155222	A. BUILDING	01	COMPLETED 09/22/2011
133222			B. WING		09/22/2011
NAME OF P	ROVIDER OR SUPPLIER		l	T ADDRESS, CITY, STATE, ZIP CODE	
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			I	WEST LINCOLN ROAD OMO, IN46902	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
The facility has a capacity of 131 and had					
	a census of 99 at	the time of this survey.			
	•	by Lex Brashear, Life cialist-Medical Surveyor			
	011 037 207 11.				
	The facility was	found not in compliance			
	-	ntioned regulatory			
	requirements as 6	• •			
	following:				
K0051 SS=E	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted				
	200 feet of nurse's located in the path written records of reliable second so Fire alarm systems	ual pull stations are within stations. Pull stations are of egress. Electronic or tests are available. A urce of power is provided. If particular are maintained in IFPA 72 and records of			
	is remote annuncia system to an appre	tept readily available. There ation of the fire alarm oved central station.			
	facility failed to detectors on 100 location which we detector to function	ention and interview, the ensure 3 of 22 smoke hall were installed in a rould allow the smoke on to its fullest A 72, 2-3.5.1 requires in	K0051	K0051A. Smoke detectors identified in the statement of deficiency for 100 hall was replaced.B Any resident that resides on 100 hall had the potential to be affected, how no negative outcomes were	t ever
	.ry	,		identified.C. Smoke detector	rs will

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NU		IDENTIFICATION NUMBER:	A. BUILI	DING	01	COMPI	LETED
∥ 155222 		B. WING			09/22/2	011	
NAME OF BROWDER OF GUIDNIER				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				429 WE	ST LINCOLN ROAD		
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO					1O, IN46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	+	IAG	be placed at least 3 feet from	n	DATE
	spaces served by air handling systems, detectors shall not be located where air				exhaust vents. Maintenance		
					personel was educated on the	e	
		eration of the detectors.			components of K0051.D.		
	_	actice could affect 30			Monitoring of this tag will be	ive tional	
		hall as well as visitors			responsibility of the Executiv Director/designee.Observation		
	and staff.				rounds weekly times 3 month		
	Findings include:				then quarterly thereafter to ensure that smoke detectors installed correctly.Results of	are	
	Based on observa	ations on 09/22/11 during			monitoring will be taken to		
		12:45 p.m. and 1:20 p.m.			Performance Improvement		
	with the Maintenance Supervisor, the following smoke detectors were within				meeting monthly to determin continued compliance and/o		
					the committee recommends	i diitii	
	three feet of an a				discontinuation of monitoring	jΕ.	
		etector to the north of the			10-22-2011		
		ation was within two feet					
	of an air supply v						
	* * *	etector next to room 115					
		l was two feet from an					
	air supply vent.	i was two feet from an					
		etector on 100 hall west at					
		Il next to the exit was two					
	feet from an air s						
	Based on intervie						
		each observation, it was					
	acknowledged by the Maintenance Supervisor the aforementioned smoke detectors were installed within three feet from an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability.						
	3.1-19(b)						
	3.1 - 19(b)						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	NING	01	COMPLETED	
1		155222	B. WING			09/22/2	011
			D: WENG		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ST LINCOLN ROAD		
KINDREI	TRANSITIONAL (CARE AND REHAB-KOKOMO			O, IN46902		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
K0066 SS=F	Smoking regulations are adopted and include no less than the following provisions:						
	 (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 						
	Based on observation interview, the fact I areas where sm provided with more closing covers in could be extinguing practice could after the smoking shad where residents a allowed to smoke Findings include Based on observation.	ation, record review and cility failed to ensure 1 of noking was permitted was etal containers with self to which cigarette butts ished. This deficient feet 3 staff observed in ck southeast of 400 hall and visitors were also e.	K00	066	K0066A. Smoking recepticle were immediately covered. But resident was identified to have been affected. C Effective 10-1-2011 Kindred Transition Care and Rehabilitation beca "smoke free" for staff. Ashtra were removed from smoking areas outside 400 hall. No smoking signs posted on entrance/exit doors. Staff in-serviced on no smoking policy.D. The monitoring of this tag will be the direct responsibility of the Executive Director/Designee.Observation on the property of the control of	No ve aal ame ays e onal	10/22/2011
p.m. with the Maintenance Supervisor, the				observations for 6 months wi	ll be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I I		(X3) DATE SURVEY COMPLETED	
155222		A. BUILDING	01 COMPLETED 09/22/2011		
			B. WING	CADDRESS CITY STATE ZID CODE	00/22/2011
NAME OF F	PROVIDER OR SUPPLIER		ı	FADDRESS, CITY, STATE, ZIP CODE ST LINCOLN ROAD	
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			l l	0MO, IN46902	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG		tside 400 hall southeast	IAU	completed to ensure that sel	+
	_	th open metal containers		closing cover is present on n	
	_	ing covers where over	ashtrays. Only ashtray present		ent
	one hundred ciga	_		will be at front entrance for	
	_	dition, an alternate		visitors to extinguish prior to entry.Results of this monitori	na
	•	acent and east of the		will be taken to Performance	
		ad a metal tray without a		Improvement meeting month	- 1
	_	r where over one hundred		review to determine continue compliance and or until the	ea
	_			committee recommends	
	cigarette butts were deposited. Based on record review on 09/22/11 at 3:15 p.m. the smoking policy indicated cigarettes			discontinuing of monitoring.E	<u>.</u>
				10-22-2011	
		ted into a metal container			
	-	g cover. Based on			
		22/11 concurrent with			
	each observation	it was acknowledged by			
		Supervisor metal			
	containers with s	self closing covers were			
	not provided in the	he smoking shack or just			
	outside and to the	e east of the smoking			
	shack.				
	3.1-19(b)				
K0069 SS=E	Cooking facilities a with 9.2.3.	are protected in accordance .2.6, NFPA 96			
	Based on observa	ation and interview, the	K0069	K0069A. Placard was	10/22/2011
	-	install and maintain 1 of		immediately placed above the extinguisher in the cooking	e
	_	1 cooking facilities in accordance with the		facility.B. No residents were	
	requirements of NFPA 96, 7-2.1.1 which requires a placard identifying the use of	•		identified to have een affecte	ed.C.
			Maintenance was in-serviced		
	_	as a secondary backup		the requirements of life safet code K069.D. Monitoring of the	·
		omatic fire suppression		plan of correction will be the	
	· ·	conspicuously placed near		direct responsibility of the	
	•	e extinguisher in the		Executive Director/designee Observational audits will be	.
	cooking area. Ac	dditionally, NFPA 10,		Observational addits will be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 94CY21 Facility ID:

000127

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 09/22/20	ETED	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 WEST LINCOLN ROAD KOKOMO, IN46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	1998 Edition, 2-2 extinguishers pro of cooking applia cooking media (vand fats) shall be Class K fires. 2-shall be conspicue extinguisher whi protection system to using the fire of fixed fire extinguation automatically should be cooking appliance and the cooking appliance and the fixed portable fire extinustance, the portable fire extinustance could afford southeast hall as Findings include Based on observe p.m. with the Mathere was a Class extinguisher in the kitchen which latinustry in the Maintenance	3.2 requires fire evided for the protection ances use combustible vegetable or animal oils elisted and labeled for 3.2.1 requires a placard rously placed near the ch states the fire in shall be activated prior extinguisher. Since the hishing system will at off the fuel source to riance, it is preferential to a system before using a requisher. In this rable fire extinguisher is rection. This deficient fect 12 residents on 400 well as visitors and staff. Exaction on 09/22/11 at 2:08 rintenance Supervisor, as K portable fire resouth end of the calcal placard. Based on 22/11 at 2:10 p.m. with Supervisor it was re Class K portable fire			conducted 1 time weekly for months and results will be to to Performance Improvemer meeting monthly until such to the committee recommends discontinuation of monitoring 10-22-2011	aken nt ime	

000127